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AIDS Knowledge, Attitudes, Beliefs and Behaviors in a Household Survey of Filipinos in San Francisco

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Volume I

FINDINGS, SUMMARY AND CONCLUSIONS

April 20, 1990

A Joint Project of
The San Francisco Department of Public Health
AIDS Surveillance Office,
The Asian American Health Forum,
Filipino Task Force on AIDS - Northern California

Conducted by

Lydia Gorrez, Ph.D., and Maria Rosario G. Araneta, M.P.H.
Co-Principal Investigators

Jaime Geaga, PA-C, Project Manager

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EXECUTIVE SUMMARY

A population-based household survey to measure AIDS knowledge, attitudes, beliefs and behaviors in San Francisco's Filipino community was conducted between October 1989 through January 1990. Four hundred randomly selected self-identified Filipinos were interviewed in person by trained interviewers using standardized questionnaires translated into three Filipino languages. Sampling was limited to 15 census tracts with high densities of Filipino residents, (defined as census tracts where s are Filipinos, according to the 1980 Census) to maximize the ipino respondents through door-to-door canvass. The selected the following neighborhoods: Excelsior, Bernal Heights, e, South of Market, Glen Park, Portola and Mission.

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Characterisitics of the sampled 400 respondents were compared to available 1980 census information on demographic characteristics of Filipinos. Age distribution and marital status were similar among the 400 respondents and the 38,365 Filipinos accounted for in the 1980 census, but males and Filipinos born in the United States were

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EXECUTIVE SUMMARY

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A standardized questionnaire was developed to solicit 271 responses about demographic information, health care concerns, knowledge about HIV-1 transmission and prevention, attitudes and beliefs about AIDS, self-identified high risk behaviors and access to AIDS education. Four hundred and twenty five (425) self-identified Filipinos were identified through either a reverse telephone directory or door to door canvass and invited to be interviewed. Of these, 25 refused, resulting in a non-compliance rate of 5.8%. Of the 400 who agreed to participate, none refused to complete the survey, resulting in a non-response rate of (0%).

Characterisitics of the sampled 400 respondents were compared to available 1980 census information on demographic characteristics of Filipinos. Age distribution and marital status were similar among the 400 respondents and the 38,365 Filipinos accounted for in the 1980 census, but males and Filipinos born in the United States were

underrepresented in the sampled cohort. The underrepresentation of U.S. born Filipinos (6% compared to 30% in 1980 census) is probably attributable to the fact that census tracts with high densities of Filipinos
tend to be comprised of recent immigrants. Longer term immigrants and subsequent generations of Filipinos tend to live away from such census tracts.

Knowledge about HIV-1 transmission was measured through 24 true/false questions about established and casual modes of transmission. AIDS knowledge scores were calculated as the percentage of correct answers. Overall knowledge scores were low (mean:58.2%, 13.98/24). AIDS knowledge scores were significantly higher among individuals who were never married (63.9%), born in the United States (75.0%), and with reported behavioral risk factors for AIDS (69.8%). AIDS knowledge scores varied by education and household income, however the relationship did not follow a linear trend. AIDS knowledge scores did not vary by gender.

Common errors about modes of HIV-1 transmission included the belief that AIDS is caused by sharing toothbrushes or razors with HIV-infected persons (66%), by needles used for vaccinations or laboratory tests (57%), by receiving a blood transfusion after 1985 (54%), by donating blood (42%) and via mosquito bites (35%).

Twenty four (6.0%) individuals reported a risk factor for AIDS acquisition including having unprotected sex with homosexuals, bisexuals, HIV-1 infected persons, female prostitutes, transfusion recipients (prior to 1985), multiple sex partners and persons with venereal diseases and unknown sex histories. None of the 400 respondents reported intravenous drug abuse nor having an IVDU sex partner.

These 24 individuals were more likely to be male, young (median age: 26 years),

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never married and born in the United States. While their AIDS knowledge scores were significantly higher compared to individuals with no reported behavioral risk factor for AIDS, AIDS knowledge among these individuals did not correlate with sexual behavior modification or practice of risk reduction. Persons with risk factors for AIDS were significantly more likely to have multiple sex partners and to use drugs, including cocaine, crack, marijuana, pcp, speed and qualudes and were more likely to use drugs or alcohol during sex.

This survey has identified that in a sampled population of low to middle income Filipinos, only 24 (6%) have reported risk behaviors, 9 of whom are U.S. born. These 9 individuals comprise 37.5% of the (coincidentally) 24 U.S. born Filipinos or 6% of the 400 respondents. Of the 24 with reported high risk behavior, only 2 (0.5%) of the entire cohort were men who had sex with men. While the low proportion of individuals at risk in these specific neighborhoods are encouraging, the data do not represent behavioral risk factors for all Filipinos in San Francisco. Filipinos in San Francisco, New York, and Los Angeles continue to have the highest AIDS incidence among the Asian AIDS cases. Of these, over 75% occur among men having sex with men, who do not generally reside in neighborhoods with high densities of Filipinos. The fiscal and logistic constraints in limiting sampling to high density Filipino areas also resulted in an underestimation of U.S. born Filipinos, whose sexual and drug practices may differ from those sampled. Thus, to apply a risk for AIDS acquisition rate of 6% to all Filipinos in San Francisco would be inappropriate and underestimate the true risk for AIDS acquisition.

It is significant that of the 24 high-risk individuals, 9 or 37.5% are U.S. born, especially considering that of the sample, U.S. born Filipinos constitute only 6%, even

granted (a final and strong caveat) that the finding may not be generalizable. The implications are far-reaching.

Assuming that the 1990 Census will yield a similar finding reported in the 1980 Census that 30% of Filipinos would also be U.S. born, then a closer estimate of U.S. born Filipinos with high risk behavior for AIDS could be 37.5% of that 30%.

However, reliable estimates of the rate of risk of AIDS acquisition that are generalizable to all of San Francisco's Filipinos can only be obtained through population-based sampling in San Francisco's 154 census tracts, based on 1990 censal data to correct for demographic changes in the population, and to accomodate the other half (53%) of San Francisco's Filipinos who do not reside in census tracts densely populated with Filipinos. Understandably, this methodologic alternative is costly and laborious.

The underrepresentation of homosexual men (0.5%) in the sampled cohort and the disproportionate increase in AIDS incidence among Filipino homosexual/bisexual men in San Francisco, point to the need for methodologically appropriate KABB studies among Filipino gay men, in census tracts where Filipino gay males are likely to reside, but more urgently, public health efforts should be directed towards aggressive prevention strategies. The belief that HIV-1 can be transmitted through casual modes this late into the San Francisco AIDS epidemic, suggests a need for AIDS education specific and comprehensible to the Filipino community. Finally, the engagement of young, U.S. born Filipinos in unprotected sex with multiple partners, coupled with their significantly increased likelihood for drug (non-intravenous) utilization requires immediate intervention for the prevention of AIDS, other sexually transmitted diseases and drug addiction.